STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for a Recertification and State Licensure. Survey dates: April 4, 5, 6, 7, and 8, 2011 Facility number: 000468 Provider number: 155378 AIM number: 100290270 Survey team: Rita Mullen, RN, TC Janet Stanton, RN Michelle Hosteter, RN Census bed type: SNF/NF: 124 Total: 124 Census payor type: Medicare: 16 Medicaid: 73 Other: 35 Total: 124 Sample: 24 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed on April 14, 2011 by Bev Faulkner, RN	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
SS=D	Based on observation, interview, and record review, the facility failed to develop a care plan identifying swallowing strategies for 1 of 1 residents with a swallowing problem (Resident #84) and failed	F0279	The facility requests that this plan of correction be considered its credible allegation of compliance. Submission of the response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to develop a care plan for the monitoring of fluid intake for a resident receiving dialysis and on fluid restrictions for 1 of 1 resident reviewed with fluid restrictions (Resident # 11). This deficient practice affected 2 of 24 residents reviewed for care plan development in the sample of 24. Findings include: During initial tour on 4/4/11 at 10:08 A.M., with the Staff Development Coordinator, Resident # 84 was not identified as having any swallowing concerns. The record of Resident # 84 was reviewed on 4/6/11 at 9:30 A.M., and		facts alleged or the corrections of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this time frame should in no way be of non-compliance or admission by the facility. **F279** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: **Resident #11's physician has been contacted with an order received to discontinue fluid restriction.** **Resident #84's care plan and CNA assignment sheet were updated with the Speech Therapy recommendations at the time of ISDH survey.** The corrective action taken for those	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	included, but were not limited to: the diagnoses of pneumonia, obsessive compulsive disorder, and severe mental retardation. A speech therapy document, dated 10/22/10, recommended the following: "...take small bites and small sips and to sit at 90 degrees at meals and encourage to drink all fluids and in between meal liquids..." In reviewing the care plan, dated 8/17/10 with		resident having the potential to be affected by the same deficient practice is: **No other residents currently have fluid restriction orders.** **All records were audited to ensure therapy recommendations are implemented, as necessary, with care plans and CNA assignment sheets updated accordingly.** The measure put into place and systemic change made to ensure the deficient practice does not recur is: **Nursing staff have been educated on comprehensive care plans and development of care plans, including but not limited to necessity of fluid intake monitoring and implementation of any therapy recommendations. Therapy and licensed nursing staff have been re-educated on providing communication between the two departments to ensure proper interventions for all residents are in place.** **The Clinical Case Manager, MDS Coordinator, or designee, will randomly monitor a minimum of 5 care plans weekly for 60 days, to assure that necessary care plans are developed.** To ensure the deficient practice does not recur, the monitoring system established is:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a revision date of 3/24/11, the care plan noted, "..(06) monitor diet tolerance and refer to Speech Therapy if indicated. (07) Resident will be properly positioned in chair for meals and staff will ensure food items are within resident's reach..." During observation of Resident #84 at supper on 4/6/11 at 5:40 P.M., the resident was eating mashed potatoes and drinking milk when she started to cough. The resident's face became		**DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	very red and she coughed for 5 minutes. Two staff members(one of them was LPN #1-the unit manager) came to the table and asked if she was all right. Resident shook her head yes, but continued to cough. No staff told the resident to take smaller bites or sips or encouraged her to drink her fluids. In an interview with CNA #2 on 4/7/11 at 1:25 P.M., the CNA was queried about where instructions would be found for CNA's for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	special feeding techniques for Resident #84. CNA #2 indicated if there was special assistance needed regarding feeding for residents it would be found on the CNA assignment sheet. The CNA reviewed the sheet and there were no recommendations on the sheet. The CNA indicated they encourage the resident to slow down if they notice she is choking on food and to slow down when drinking.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview immediately following interview with CNA, LPN #1 was asked the location of where feeding assistance information for CNA's is kept. LPN # indicated information was on the CNA sheet as well as it should be identified on the care plan. LPN #1 indicated she was not aware Resident #84 had any specific strategies for feeding. She looked at Speech Therapy notes and saw that there was swallowing strategies mentioned, but there was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	no outlined recommendations anywhere she could find and it was not on the care plan. She indicated this was the first she knew that this resident had problems with this. She stated she was going to talk to speech therapy to see what the strategies were and would update the care plan and CNA sheet.			
SS=D	2. The clinical record of Resident #11 was reviewed on 4/8/11 at 9:15 A.M. Diagnoses for Resident #11 included, but were not limited to, end stage renal disease and dementia. A Physician's order, dated 1/13/11, indicated the Resident was on fluid		The facility requests that this plan of correction be considered its credible allegation of compliance. Submission of the response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the administrator, or any	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	restrictions and the limit was 1800 cc (cubic centimeters) a day. An "Individual Resident Meal Intake Record, dated for the month of February, indicated the total amount of the meals eaten, it did not indicate the amount of fluids taken in by the resident during a meal. There was no Plan of Care indicating the amount of fluids dietary would give or the amounts nursing would offer the Resident daily. During an interview with the Dietary worker #13, on 4/8/11 at 9:50 A.M., she indicated dietary gives Resident #11: 11 oz. with breakfast, 4 oz. with lunch and 4 oz. with supper. They don't monitor the fluids, nursing tracks the Resident's fluids. During an interview with RN #12, on 4/8/11 at 10:00 A.M., she indicated Intake and Output (I&O) was not being monitored. There was no record of Resident #11's fluid intake. 3.1-35(a)(1)		employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this time frame should in no way be of non-compliance or admission by the facility. **F279** It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: **Resident #11's physician has been contacted with an order received**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			to discontinue fluid restriction. **Resident #84's care plan and CNA assignment sheet were updated with the Speech Therapy recommendations at the time of ISDH survey.** The corrective action taken for those resident having the potential to be affected by the same deficient practice is: **No other residents currently have fluid restriction orders.** **All records were audited to ensure therapy recommendations are implemented, as necessary, with care plans and CNA assignment sheets updated accordingly.** The measure put into place and systemic change made to ensure the deficient practice does not recur is: **Nursing staff have been educated on comprehensive care plans and development of care plans, including but not limited to necessity of fluid intake monitoring and implementation of any therapy recommendations. Therapy and licensed nursing staff have been re-educated on providing communication between the two departments to ensure proper interventions for all residents are in place.** **The Clinical Case Manager, MDS Coordinator, or designee, will**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			randomly monitor a minimum of 5 care plans weekly for 60 days, to assure that necessary care plans are developed. To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. A. Based on record review and interview, the facility failed to follow a physician's order for a P.R.N. [as needed] insulin according to a sliding scale key, for 1 of 2 residents reviewed who were receiving a P.R.N. sliding scale insulin; in a sample of 24 residents reviewed. [Resident #59] B. Based on record review and interview, the facility failed to monitor and document the amounts of fluids consumed for 1 of 1 resident reviewed who had a physician's order for a fluid restriction; in a sample of 24 residents reviewed. [Resident #11]	F0282	**F282** The corrective action taken for the resident found to have been affected by the deficient practice was: **Resident #59's physician was notified with new orders received.** **Resident #11's physician has been contacted with an order received to discontinue fluid restriction.** **Resident #69 had a TSH level obtained during the ISDH survey. Physician was notified of the lab result.**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	C. Based on record review and interview, the facility failed to obtain laboratory tests which were ordered by the physician for 3 of 3 residents; in a sample of 24 residents reviewed. [Residents #69, #85, and #92] Findings include: A.1. The clinical record for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, a C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, seizure disorder, depression, and insulin-dependent diabetes. The April 2011 physician order recap [recapitulation] sheet listed orders that included, but were not limited to, the following: 1/21/11-Lantus insulin, 60 units routinely every evening; and 2/7/11--Lantus insulin, 15 units routinely every morning. On 9/3/10, an Accu-check [finger stick blood sugar test] was ordered to be done twice a day, with Humulin R insulin to be given P.R.N. according to a sliding scale. On 2/7/11, the Accu-check order was changed and was to be done weekly at 4:00 P.M. The sliding scale for the P.R.N. insulin, dated 9/3/10, was ordered as follows:		**Resident #85 had BMP, CBC, liver profile, and TSH obtained and physician has been notified of the lab results.** **Resident #92's physician is aware of the 3/9/2011 CBC result with no new orders obtained.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **The glucometer flow records of all residents have been reviewed with physician notifications made as necessary.** **No other residents currently have fluid restriction orders.** **A full house audit has been conducted to ensure all ordered labs have been obtained.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses have been re-educated on provision of care in accordance with the plan of care, including but not limited to assessment of blood sugars and following sliding scales insulin orders, necessity of fluid intake monitoring, and obtaining of ordered laboratory tests.** **A performance improvement tool**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Less than 110=0 [zero] units 111-150=2 units 151-200=4 units 201-250=8 units 251-300=12 units 301-350=15 units 351-400=20 units Greater than 400=Notify M.D. If no call from M.D. within 30 minutes, give 22 units. The "Diabetic Monitoring Flow Sheet" form was identified on 4/6/11 at 1:00 P.M. by L.P.N. #9 as the form used to document blood sugar test results and amounts of P.R.N. insulin give, and any notification to the physician that was done. The "Diabetic Monitoring Flow Sheet" forms for Resident #59, from 11/13/10 through 2/28/11,had documentation of blood sugar test results that would have required a P.R.N. dose of insulin, but had no documentation that any was given, as follows: 11/16/10, 6:00 A.M.--Blood sugar of 173. The resident should have received 4 units. 11/17/10, 6:00 A.M.--Blood sugar of 202. The resident should have received 8 units. 11/20/10, 6:00 A.M.--Blood sugar of 165. The resident should have received 4 units.		**has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with blood sugar testing and following sliding scale insulin orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with documentation of fluid intake, as necessary.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with obtaining ordered laboratory tests.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	11/25/10, 6:00 A.M.--Blood sugar of 128. The resident should have received 2 units. 11/26/10, 6:00 A.M.--Blood sugar of 203. The resident should have received 8 units. 11/27/10, 6:00 A.M.--Blood sugar of 222. No insulin was recorded as given, and the blood sugar was re-checked at 7:00 A.M. with a result of 189. The resident should have received at least 4 units. 12/1/10, 6:00 A.M.--Blood sugar of 137. The resident should have received 2 units. 12/3/10, 6:00 A.M.--Blood sugar of 173. The resident should have received 4 units. 12/4/10, 6:00 A.M.--Blood sugar of 187. The resident should have received 4 units. 12/6/10, 6:00 A.M.--Blood sugar of 119. The resident should have received 2 units. 12/8/10, 6:00 A.M.--Blood sugar of 159. The resident should have received 4 units. 12/9/10, 6:00 A.M.--Blood sugar of 181. The resident should have received 4 units. 12/10/10, 6:00 A.M.--Blood sugar of 150. The resident should have received 2 units. 12/17/10, 5:56 A.M.--Blood sugar of 156. The resident should have received 4 units. 12/18/10, 6:00 A.M.--Blood sugar of 128. The resident should have received 2 units. 12/20/10, 6:00 A.M.--There was no documentation of a blood sugar level. 12/21/10, 6:00 A.M.--Blood sugar of 138. The resident should have received 2 units. 12/22/10, 6:00 A.M.--Blood sugar of 257. The resident should have received 12 units.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12/24/10, 6:00 A.M.--Blood sugar of 196. The resident should have received 4 units. 12.24.10, 4:00 P.M.--Blood sugar of 438. The resident should have received 22 units. The box indicating the physician had been notified was checked, but there was no documentation that insulin was administered. 12/26/10, 6:00 A.M.--Blood sugar of 114. The resident should have received 2 units. 12/27/10, 6:00 A.M.--Blood sugar of 120. The resident should have received 2 units. 12/29/10, 6:00 A.M.--Blood sugar of 203. The resident should have received 8 units. 12/30/10, 6:00 A.M.--Blood sugar of 205. The resident should have received 8 units 1/2/11, 6:00 A.M.--Blood sugar of 147. The resident should have received 2 units. 1/3/11, 6:00 A.M.--Blood sugar of 288. The resident should have received 12 units. 1/6/11, 6:00 A.M.--Blood sugar of 201. The resident should have received 8 units. 1/18/11, 6:00 A.M.--Blood sugar of 255. The resident should have received 12 units. 1/19/11, 6:00 A.M.--Blood sugar of 135. The resident should have received 2 units. 1/21/11, 6:00 A.M.--Blood sugar of 127. The resident should have received 2 units. 1/23/11, 6:00 A.M.--Blood sugar of 117. The resident should have received 2 units. 1/27/11, 6:00 A.M.--Blood sugar of 209. The resident should have received 8 units.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The boxes to document the amounts administered were blank for all of the entries listed above.

The order for the blood sugar was changed on 2/7/11 to be done weekly at 4:00 P.M. On 2/7/11, 6:00 A.M., the blood sugar was recorded as 113. The resident should have received 2 units, but the box to document the amount administered was blank.

During daily conferences on 4/7/11 at 3:30 P.M. and 4/8/11 at 11:00 A.M., the Director of Nursing was given the opportunity to provide the "Diabetic Monitoring Flow Sheet" forms for the month of March, 2011. At the final exit on 4/8/11 at 4:00 P.M., the March 2011 forms were not provided for review.

The April 2011 "Diabetic Monitoring Flow Sheet" form was located in the current Medication Administration Record [M.A.R.] binder. An entry for 4/4/11 at 4:00 P.M., documented the weekly blood sugar check level as 127. The resident should have received 2 units. The box to document the amount of insulin given was blank.

The M.A.R.s for January, February, March, and April 2011 were reviewed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The orders for the Accu-check and P.R.N. sliding scale insulin were listed, but all boxes for each day of the month had a capital "X" marked. The order for the Accu-check indicated "See Diabetic Monitoring Flow Sheet." During the daily conference on 4/7/11 at 3:00 P.M., the Director of Nursing was given the copies of the "Diabetic Monitoring Flow Sheet" forms, high-lighting the dates that no insulin was recorded. In an interview at that time, she indicated she would have to check to see if the insulin amounts were recorded some other place. She confirmed that the "Diabetic Monitoring Flow Sheet" form was to be used to document all blood sugar levels and amounts of P.R.N. insulin given. The forms were returned on 4/8/11 at 9:00 A.M., with no additional information attached. During the final exit on 4/8/11 at 4:00 P.M., the Director of Nursing indicated she had no additional documentation to provided for review.			
SS=E	B.1. The clinical record of Resident #11 was reviewed on 4/8/11 at 9:15 A.M. Diagnoses for Resident #11 included, but were not limited to, end stage renal disease and dementia.		**F282** The corrective action taken for the resident found to have been affected by the deficient practice was: **Resident #59's physician was**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's order, dated 1/13/11, indicated the Resident was on fluid restrictions and the limit was 1800 cc (cubic centimeters) a day. A Plan of Care, dated 10-/28/10 and reviewed on 1/25/11, indicated the following: "Problem: End Stage Renal Disease, potential for altered fluid balance.... Approach: (1) Diet as order. (2) Encourage compliance with diet and fluid restriction. (3) Assess for fluid overload...." There was no indication of the amount the Resident was to receive with meals or medications. An "Individual Resident Meal Intake Record, dated for the month of February, indicated the total amount of the meals eaten, it did not indicate the amount of fluids taken in by the resident during a meal. During an interview with the Dietary worker #13, on 4/8/11 at 9:50 A.M., she indicated dietary gives Resident #11: 11 oz. with breakfast, 4 oz. with lunch and 4 oz. with supper. They don't monitor the fluids, nursing tracks the Resident's fluids. During an interview with RN #12, on 4/8/11 at 10:00 A.M., she indicated Intake and Output (I&O) was not being		**notified with new orders received.** **Resident #11's physician has been contacted with an order received to discontinue fluid restriction.** **Resident #69 had a TSH level obtained during the ISDH survey. Physician was notified of the lab result.** **Resident #85 had BMP, CBC, liver profile, and TSH obtained and physician has been notified of the lab results.** **Resident #92's physician is aware of the 3/9/2011 CBC result with no new orders obtained.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **The glucometer flow records of all residents have been reviewed with physician notifications made as necessary.** **No other residents currently have fluid restriction orders.** **A full house audit has been conducted to ensure all ordered labs have been obtained.** The measures put into place and systemic change made to ensure the deficient practice does not recur is:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	monitored.		**Licensed nurses have been re-educated on provision of care in accordance with the plan of care, including but not limited to assessment of blood sugars and following sliding scales insulin orders, necessity of fluid intake monitoring, and obtaining of ordered laboratory tests.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with blood sugar testing and following sliding scale insulin orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with documentation of fluid intake, as necessary.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with obtaining ordered laboratory tests.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			monitoring thereafter. **Completion Date: April 25, 2011**	
SS=E	C. 1. The record of Resident #85 was reviewed on 4/6/11 at 1:15 P.M.. Diagnoses for Resident #85 included, but were not limited to, hypothyroidism, seizure disorder, hypoglycemia and anemia. In reviewing physician's orders there was no current changes in lab draws for the following orders. A lab draw order for a BMP [basic metabolic panel], CBC [complete blood count], liver profile, and TSH [thyroid stimulating hormone] every six months due in March and September. In reviewing laboratory results in the chart, none of these results were found for March 2011. In an interview with the DON (Director of Nursing) on 4/6/11 at 8:50 A.M., after providing information on labs for one resident, request of any more lab results was made and she indicated she had no more information. C. 2. The record for Resident #69 was reviewed on 4/6/11 at 9 A.M.		**F282** The corrective action taken for the resident found to have been affected by the deficient practice was: **Resident #59's physician was notified with new orders received.** **Resident #11's physician has been contacted with an order received to discontinue fluid restriction.** **Resident #69 had a TSH level obtained during the ISDH survey. Physician was notified of the lab result.** **Resident #85 had BMP, CBC, liver profile, and TSH obtained and physician has been notified of the lab results.** **Resident #92's physician is aware of the 3/9/2011 CBC result with no new orders obtained.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **The glucometer flow records of all residents have been reviewed with physician notifications made as**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Diagnoses for Resident #69 included, but were not limited to, hypothyroid, anxiety, schizophrenia, and head injury. In reviewing physician's orders there were no changes in lab draws for the following orders. A lab draw order, dated 3/11/10, to draw a lipid panel and TSH every six months on March and September. There were no lab results for a TSH for March 2011 found. In an interview with the DON (Director of Nursing) on 4/6/11 at 8:50 A.M., after providing information on labs for another resident, request of any more lab results was made and she indicated she had no more information. C.3. The record for Resident #92 was reviewed 4/5/11 at 11 A.M. Diagnoses for Resident #92 included, but were not limited to, brain injury, dementia, hypertension, depressive disorder, osteoporosis. A current physician's order dated 5/9/09, indicated CBC to be done every six months on August and February. A review of lab results indicated the lab had been drawn 3/9/11.		**necessary.** **No other residents currently have fluid restriction orders.** **A full house audit has been conducted to ensure all ordered labs have been obtained.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses have been re-educated on provision of care in accordance with the plan of care, including but not limited to assessment of blood sugars and following sliding scales insulin orders, necessity of fluid intake monitoring, and obtaining of ordered laboratory tests.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with blood sugar testing and following sliding scale insulin orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with documentation of fluid intake, as necessary.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview with the DON (Director of Nursing) on 4/6/11 at 8:50 A.M., after providing information on labs for one resident, request of any more labs was made and she indicated she had no more information. 3.1-35(g)(2)		**days of work, for 30 days, compliance with obtaining ordered laboratory tests.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	
F0309 SS=E	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure the monitoring of the bowel movement records by the licensed nursing staff and ensure treatment of those residents at risk for	F0309	**F309** The corrective action taken for the residents found to have been affected by the deficient practice was: **Therapy has evaluated Resident #57 with preventative interventions updated. Resident #57's care plan and CNA assignment sheet have been reviewed and updated to reflect current interventions.** **BM records for Resident #s 6, 30, 57, 69, 92, and 126 have been reviewed. No treatment for constipation was necessary for**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	constipation and failed to assess factors in attempt to prevent non-pressure ulcers for 1 of 7 residents reviewed for skin breakdown This impacted 6 of 24 residents reviewed for constipation in a sample of 24 (Residents 6, 30, 57, 69, 92 and 126) and 1 of 7 (#57) residents reviewed for skin ulcers in a sample of 24. Findings include: 1. The clinical record of Resident #126 was reviewed on 4/7/11 at		**these residents.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been updated accordingly.** **All residents have the potential to be affected by lack of monitoring of bowel movements, thus this plan of correction applies to all residents.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to ulcer prevention and the newly implemented BM protocol.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	12:30 P.M. Diagnoses for Resident #126 included, but were not limited to, chronic renal insufficiency, dementia and congestive heart failure. The Bowel Movement (BM) records, for the months of January and February 2011, indicated Resident #126 did not have a BM for six days, January 1st to the 6th and eight days January 28th to February 4th. The Medication		**measures to prevent ulcers, and monitoring of residents at risk for constipation with treatment implemented, as necessary.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration Record (MAR), dated for the months of January and February 2011, indicated an order, dated 12/7/10, for Bisac-evac 10 mg (milligrams) supp-insert one PR (per rectum) as needed for constipation. The Resident did not receive this medication for constipation in January or February 2011. 2. The clinical record of Resident # 30 was reviewed on 4/6/11 at 3:00 P.M.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Diagnoses for Resident# 30 included, but were not limited to, Depression, Diabetes and osteoarthritis. A Plan of Care, dated 3/15/11, indicated the Resident was "At risk for constipation...r/t (related to) occasional constipation, pain meds, decreased mobility." Approaches included, but were not limited to "...Monitor elimination sheet to monitor frequency of BM's..." A Physician's order,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 3/4/11, indicated "Dulcolax Supp 10 mg (milligrams) po [by mouth] every three days as needed for constipation." The Bowel Movement (BM) record, for the month of March 2011, indicated Resident # 30 did not have a BM for five days March 6th to the 10th, for five days the 12th to the 16th and for six days the 23rd to the 28th. The MAR, dated for the month of March 2011,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated the Dulcolax Supp 10 mg (milligrams) po [by mouth] every three days as needed for constipation had not been administrated during the month of March 2011. 3. The clinical record of Resident # 6 was reviewed on 4/6/11 at 1:00 P.M. Diagnoses for Resident # 6 included,but were not limited to, arthritis and chronic constipation. A Plan of Care, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/10/11, indicated the Resident was "At risk for constipation/dehydration r/t decrease mobility, c/o (complaint of) constipation. Goal: Resident will have BM at minimum q (every) 3 days..." Approaches included, but were not limited to "...Monitor for s/s (signs and symptoms) of constipation, notify MD of unresolved constipation." The Bowel Movement (BM) record, for the month of January 2011, indicated Resident # 6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	did not have a BM for seven days January 3rd to the 9th and for five days January the 16th to the 20th. The MAR, dated for the month of January 2011, indicated "Senokot two po (by mouth) daily for chronic constipation" was not started until January 25th. During an interview with LPN #14, on 4/6/11 at 2:30 P.M., indicated the "N" on the BM record means no bowel movement, so she didn't			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	have a BM on those days.			
SS=E	4. In an interview during the initial orientation tour on 4/4/11 at 10:05 A.M., L.P.N. #3 indicated Resident #57 required staff to provide all of his daily care, used a mechanical lift for transfers, had multiple open areas of his right lower leg due to severe P.V.D. [peripheral vascular disease], and was receiving Hospice services. The resident was not in his room at the time of the tour, but his bed was observed to have a speciality low-air loss mattress. A. On 4/4/11 at 1:32 P.M., the resident was observed in the unit Dining/Activity room. The resident was observed to be sitting in a specialty "Broda" geri-chair. There was a gel cushion in the seat of the chair. A regular, standard pillow was observed to be rolled up into a tight tube and placed under his right knee. The foot rest of the Broda was in an "up" position, so that the resident's feet were hanging down without any support for the weight of his legs. On 4/5/11 at 9:48 A.M., the resident was observed sitting in the Broda in the Dining/Activity room following the breakfast meal. The rolled pillow was		**F309** The corrective action taken for the residents found to have been affected by the deficient practice was: **Therapy has evaluated Resident #57 with preventative interventions updated. Resident #57's care plan and CNA assignment sheet have been reviewed and updated to reflect current interventions.** **BM records for Resident #s 6, 30, 57, 69, 92, and 126 have been reviewed. No treatment for constipation was necessary for these residents.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been updated accordingly.** **All residents have the potential to**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	observed under his right knee, with both legs and feet hanging down without other support. On 4/5/11 at 1:00 P.M., the resident was taken from the Dining/Activity room to be placed in bed for a dressing change by the Hospice and facility nurses. The rolled pillow was observed positioned under the resident's right knee. After the gauze dressings were removed during the dressing change, the resident was observed to have open areas of the heel, bunion, toes, and calf areas. An open area was also observed behind the right knee. In an interview on 4/5/11 at 1:15 P.M., Hospice Nurse #10 indicated a "multi-podus" specialty pressure-relief boot had been tried for his heel, but the straps caused more open areas because the resident would rub his legs together. She indicated the pillow was used under his knees to keep the heels up and for management of his right knee contracture. The nurse indicated "other things" had been tried, and would be documented in the Hospice progress notes. Hospice progress notes had documentation related to the changes in the type of foot boot used, but there were no references found that addressed pressure relief positioning devices to be used for the contracted right knee.		**be affected by lack of monitoring of bowel movements, thus this plan of correction applies to all residents.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to ulcer prevention and the newly implemented BM protocol.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of measures to prevent ulcers, and monitoring of residents at risk for constipation with treatment implemented, as necessary.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 4/6/11 at 3:45 P.M., the resident was observed sitting in the Broda chair with a rolled pillow under his right knee. The resident's feet, which were hanging down without support, were crossed at the ankle--with his left foot over the right. The clinical record for Resident #57 was reviewed on 4/4/11 at 1:35 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, urinary retention with supra-pubic catheter, hypertension, contractures, fragile skin, and hypothyroidism. Hospice services were initiated on 12/23/10. A physician's progress note, dated 2/3/11, indicated "Lower extremity P.V.D. with severe necrotic area...." A progress note dated 3/14/11 indicated "... Unavoidable skin breakdown, severe P.V.D...." The "Resident Weekly Skin Check Sheet" forms identified the development of the open areas as follows: 12/29/10--"Treatment continues to left middle finger and right heel." [no other information] 1/5/11--"Left middle finger improved. Right heel no improvement. Treatment continues. Heel foot elevator ordered by Hospice."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/12/11--Right heel continues black, yellow eschar with purulent drainage.... No new area of redness or pressure areas." On 1/12/11, the physician ordered "D/C [discontinue] Prevalon boots. Resident to wear heel lift 'boots' at all times.... Therapy [Physical Therapy--P.T.] to do dressing change Monday through Friday." 1/19/11--"Right heel remains Stage 4--Therapy [Physical Therapy] continues to treat wound." 1/26/11--"Bilateral lower extremities cool to touch, very faint PPP [popliteal pedal pulse]." Areas listed as Stage 4 were right heel, right outer heel, right 3rd toe, right inner 2nd toe, right great toe, left 2nd toe, and left 3rd toe. A "Physical Therapy Wound Care Monthly Progress Note" dated 1/28/11 indicated "... P.T. had re-educated nursing that resident should [not legible] multi-podus boots due to resident's decreased skin integrity and sensitivity to pressure and should be elevated with bolster or pillows under legs for protection...." A physician order, dated 1/26/11, indicated "Keep foot rest of Broda chair folded closed to allow resident's bilateral lower extremities to have no contact or pressure. Support bilateral lower extremities with pillows or blankets." On 2/4/11, the physician ordered "D/C P.T. to do wound therapy." On 3/1/11, the right calf area was added.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[No stage or measurements were indicated] A "Weekly Non-Pressure Skin Condition Report" form indicated a red area of 4 by 1.5 cm. [centimeters], with a 1.6 by 0.5 cm. scab was first observed behind the right knee on 3/3/11. An entry on the report form, dated 3/30/11, indicated the area was now black at 4 by 0.7 cm. A Care Plan entry, originally dated 11/30/10 and with a current update of 3/23/11, addressed the resident's open ulcers. There were multiple changes listed for specialized boots and other treatments, with standard approaches listed for nutrition and skin checks. One approach for "Positioning" indicated "When resident is out of bed, change position every 2 hours by toileting, boosting, shifting of weight, ambulating, or return to bed for rest." There were no approaches that addressed pressure-relieving devices for placement under the knee, or support for the lower legs, to minimize additional compromise to the lower extremity circulation. B. The clinical record for Resident #57 was reviewed on 4/4/11 at 1:35 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, urinary retention with a supra-pubic			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	catheter, contractures, hypothyroidism, fragile skin, and history of an intestinal abscess. The April 2011 physician order recap [recapitulation] sheet listed medications which included the following bowel management medications: 7/12/10--Milk of Magnesia [a laxative], 10 ml. [milliliters] every day P.R.N. [as needed]; 2/17/11--Senokot [a laxative, stimulant] daily at bedtime; 2/21/11--Bisacodyl [a stool softener, laxative] Suppository P.R.N. The resident was also receiving Cogentin (10/12/10), an anticholinergic, anti-Parkinson's agent with potential adverse reactions which included constipation, obstructive disease of the gastrointestinal tract, and ileus. On 3/8/11, Roxinal [Morphine sulfate] was started at 15 mg. [milligrams] sublingual routinely every 4 hours. Potential gastrointestinal adverse reactions included constipation and paralytic ileus. The "Flow Sheet Record" for January 2011 indicated the resident had a B.M. [bowel movement] at least 1 time a day from 1/1 through 1/15/11. A "0" [zero] was marked for B.M.s for 7 days from 1/16/11 ["10-6"--10:00 P.M. to 6:00 A.M. shift] through 1/23/11["6-2 "--6:00 A.M. to 2:00 P.M. shift].			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The January 2011 M.A.R. [Medication Administration Record] indicated the resident had not received any doses of the P.R.N. Milk of Magnesia. Nurse's Progress Notes for January had no documentation related to the lack of a B.M. through this period. The February 2011 "Flow Sheet Record" indicated the resident had a B.M. at least 1 time daily from 2/1 through 2/8/11, with "0" [zero] B.M.s on 2/9, 10, and 11, and a "S" [small] B.M. on the 2:00 to 10:00 P.M. shift on 2/12/11. A "0" [zero] was marked for B.M.s for 9 days from 2/13/11 ["10-6"--10:00 P.M. to 6:00 A.M. shift] through 2/21/11 ["2-10"--2:00 P.M. to 10:00 P.M. shift]. The February 2011 M.A.R. indicated the resident received Milk of Magnesia on 2/19/11 at 8:00 P.M. with "no results;" and 2/20/11 at 7:20 A.M. with no documentation of results. On 2/21/11, an order was given by the physician for "Senokot 3 tabs one time at bedtime. If no results, give Fleets [enema] in A.M. [morning]." The order for the Fleets enema was listed on the M.A.R. to be given on 2/22/11, as indicated by a box marked for that date. The box was blank with no initials from a licensed nurse indicating the enema had			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	been given. Nurse's Progress Notes had the following documentation: 2/20/11, 2:45 A.M.--"No B.M. noted at this time. Will continue to monitor." 2/20/11, 5:50 A.M.--"No B.M. No signs/symptoms discomfort." 2/20/11, 11:30 A.M.--"Gave M.O.M. No B.M. noted." 2/20/11, 9:00 P.M.--"Had smudge of B.M. on brief. Had prune juice with dinner. Gave scheduled Senokot." 2/21/11, 5:45 A.M.--"No B.M. noted this shift." 2/21/11, 9:30 A.M.--"New order for Dulcolax [Bisacodyl] Suppository...." 2/21/11, 1:30 P.M.--"Had scant B.M. Gave Bisacodyl. No results yet. Bowel sounds all 4 quadrants." The February 2011 M.A.R. listed the order for the Bisacodyl Suppository, but there was no documentation indicating the suppository had been given. 2/21/11, 8:00 P.M.--"Continue to monitor for B.M. Gave 3 Senokot as ordered. No results. New order for Fleets." 2/22/11, 2:10 A.M.--"Had moderate B.M. times 1." In an interview during the daily conference on 4/8/11 at 11:00 A.M., the Director of Nursing indicated the facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	did not have any formal policy/procedure or protocol related to bowel management.			
SS=E	5. The record for Resident #69 was reviewed on 4/6/11 at 9.A.M. Diagnoses for Resident #69 included, but were not limited to, hypothyroid, anxiety, schizophrenia, head injury, and constipation. A document titled " Flow Sheet Record " was reviewed for the months of January, February and March of 2011. For the month of January where bowel movements [BM] are recorded, the record indicated the resident did not have a BM January 4th through January 12th. The resident had physician's orders to receive Miralax and Colace for constipation daily, and a PRN [as needed] order for Colace if constipated. In reviewing the MAR[medication administration record] no PRN of Colace was given. There was no documentation noted in Nurses Notes regarding BM's. The Flow Sheet Record for March also indicated that March 19th-March 26th she did not have a bowel movement. The MAR for March 2011 did not indicated that any PRN of Colace had been given.		**F309** The corrective action taken for the residents found to have been affected by the deficient practice was: **Therapy has evaluated Resident #57 with preventative interventions updated. Resident #57's care plan and CNA assignment sheet have been reviewed and updated to reflect current interventions.** **BM records for Resident #s 6, 30, 57, 69, 92, and 126 have been reviewed. No treatment for constipation was necessary for these residents.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been updated accordingly.**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	In an interview with LPN #1 on 4/6/11 at 9:10 A.M., she indicated that if a resident did not have a bowel movement for three days, the staff should take action. The LPN indicated prune juice would be given first, and if that didn't work they would give Milk of Magnesia [MOM] or whatever order the resident has for treatment. When queried how often the nurses review the flow sheets, she stated when they can. When questioned if CNA's are to report if resident has not had a BM and she stated in the morning meeting that they are addressing this issue and trying to work out the kinks. 6. The record for Resident #92 was reviewed on 4/5/11 at 11 A.M. Diagnoses for Resident #92 included, but were not limited to, brain injury, dementia, hypertension, depressive disorder, osteoporosis. A document titled " Flow Sheet Record " was reviewed for the months of January, February and March of 2011. Resident #92 has a physician's order to receive Senekot two tablets daily and an as needed order for MOM if constipated. For the month of January, the record indicated the resident did not have a BM		**All residents have the potential to be affected by lack of monitoring of bowel movements, thus this plan of correction applies to all residents.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to ulcer prevention and the newly implemented BM protocol.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of measures to prevent ulcers, and monitoring of residents at risk for constipation with treatment implemented, as necessary.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	from January 1st through January 6th, as well as January 12th through 15th, and January 18th through January 26th. The MAR for January indicated that the resident had not received MOM for that month. For the month of February 2011, the resident did not have any BM's recorded for February 4th through February 8th, and February 16th through February 19th. The MAR did not indicate that any MOM had been given. Nurses notes were reviewed and no documentation was noted regarding BM's. In an interview with LPN #1 on 4/6/11 at 9:10 A.M., she indicated if a resident did not have a bowel movement for three days, the staff should take action. The LPN indicated prune juice would be given first, and if that didn't work they would give Milk of Magnesia [MOM] or whatever order the resident has for treatment. When queried how often the nurses review the flow sheets, she stated when they can. When asked if CNA's are to report if resident has not had a BM and she stated in the morning meeting that they are addressing this issue and trying to work out the kinks. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0314	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			
SS=D	Based on observation, interview and record review, the facility failed to implement interventions and devices to prevent pressure sores from developing, for 1 resident who developed a Stage II open area [Resident #75]; or to prevent a pressure sore from re-developing, for 2 residents who had a healed area develop to a Stage II [Residents #4 and #65]. This deficient practice impacted 3 of 7 residents reviewed for pressure sore issues, in a sample of 24 residents reviewed. Findings include: 1. In an interview during the initial orientation tour on 4/4/10 at 10:05 A.M., L.P.N. #3 indicated Resident #65 had a "healing" Stage II pressure sore of the coccyx. The clinical record for Resident #65 was reviewed on 4/5/11 at 2:30 P.M. Diagnoses included, but were not limited	F0314	**F314** The corrective action taken for the residents found to have been affected by the deficient practice was: **Resident #65s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #4 was placed on a Low Air Loss mattress at the time of ISDH survey. Resident #4s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #75s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to, diabetes, hypertension, osteoarthritis, dementia, and chronic ulcer of the right ankle. An acute hospital History and Physical, dated 8/4/10, indicated the resident had been living in an assisted living setting, and had been treated for a right ankle diabetic pressure sore for several weeks. The "Resident Weekly Skin Check Sheet" forms indicated the following: 12/31/10--"0.3 by 0.3 cm. [centimeter] Stage 4 pressure area between buttocks." Two Care Plan entries dated 12/31/10, identified the area as a Stage II. 1/8/11--"Coccyx 0.2 by 0.2 by 0.1 cm. Stage II." 1/15/11--"Stage II healing well--intact surrounding skin red/pink." 1/15/11--"Stage II on coccyx healed." 1/22/11--"Pressure wound on bottom open 0.3 by 0.3 cm. began treatment again." 1/26/11--"Coccyx area 0.5 by 0.5 by 0.2" 2/3/11--"Improved." 2/8/11--"Coccyx 0.3 by 0.5. Much improved...." 2/23/11--"Area on coccyx healed...." 3/6/11--"Area on coccyx is 3 by 0.5 cm...." 3/16/11--"Coccyx 3 by 1.2 cm. Stage II area deteriorated."		The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been updated accordingly.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to pressure ulcer prevention.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of measures to prevent pressure ulcers.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3/30/11--"Coccyx decub Stage II, 1 by 1 by 0.1 cm. A "Nurse's Progress Note" entry, dated 2/23/11 at 2:00 P.M., indicated "Area on coccyx and right outer ankle healed. Continue moisture barrier, order received to D/C [discontinue] Santyl to coccyx." A "Nurse's Progress Note" entry, dated 3/9/11 at 9:30 A.M., indicated "Noted small open area to coccyx...." One Care Plan entry, dated 12/31/11, addressed a problem of "At risk for infection related to altered skin integrity related to pressure ulcer." An intervention for a "low air loss [mattress] on bed," dated 12/31, was crossed out. A second Care Plan entry, dated 12/31/11, addressed a problem of "At risk for skin breakdown...." One of the interventions was listed as "Pressure relieving mattress. An up-dated Care Plan, dated 3/29/11, included an entry addressing "Skin/Tissue integrity.... Actual Stage II to coccyx." One of the interventions listed was: (3/29/11) Pressure relieving mattress to bed--low air loss bed." On 4/5/11 at 9:40 A.M., the resident was observed sitting in a wheelchair in the Dining/Activity room. There was a		**determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	pressure-relieving cushion in her wheelchair. The resident's bed was observed to be in a low position, and was a standard facility "pressure-reducing" mattress. On 4/8/11 at 1:20 P.M., the resident was observed in bed, laying on her right side. An unidentified C.N.A. told L.P.N. #11 that the resident had been turned on her right side since laying down after lunch. L.P.N. #11 told the resident that she wanted to look at the resident's sore area. After pulling the blankets back, the resident's coccyx area was observed. The "Duoderm" dressing that had been applied earlier had become detached at two sides and had crumpled into a ball at the coccyx area. When the nurse removed the dressing, a 4 cm. reddened area surrounding a small open area was observed at the coccyx. In an interview at that time, L.P.N. #11 indicated the open area was "about 0.1 cm." in size. The nurse told the resident that she would be back to replace the dressing. At the nurse's station, L.P.N. #11 located the current skin check sheet, and indicated the area had been measured on 4/6/11 at 0.5 by 0.3 cm.			
SS=D	2. During the initial tour, on 4/4/11 at 10:00 A.M., LPN # 3 indicated Resident # 4 had a history of a open area to the		**F314** The corrective action taken for the	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	coccyx but that it was healed. The clinical record of Resident # 4 was reviewed on 4/6/11 at 1:00 P.M. Diagnoses for Resident # 4 included, but were not limited to, end stage dementia, failure to thrive and depression. A Quarterly Minimum Data Set Assessment, dated 2/8/11, indicated Resident # 4 had a stage II pressure ulcer to the coccyx. A Plan of Care, dated 12/3/10, indicated "Res (resident) at risk for skin breakdown....Hx of healed pressure ulcer...." Approaches: included, but were not limited to, "Low bed with low air mattress...moisture barrier q shift...turn and reposition q 2 hours..." A "Daily Monitoring/Pressure Ulcer" sheet, dated for the month of February 2011, indicated a pressure ulcer had been identified on 2/2/11 and healed on 2/16/11. Resident #4 had a pressure ulcer to the coccyx. There were no measurements nor was it staged on this form. A Physician's order, dated 2/2/11, indicated "Hydrocolloid dsg (dressing) to sacrum - apply every 3 d (days)."		residents found to have been affected by the deficient practice was: **Resident #65s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #4 was placed on a Low Air Loss mattress at the time of ISDH survey. Resident #4s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #75s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A Physician's order, dated 2/16/11, indicated "Continue protective dressing to (sic) hx (history) of open areas on coccyx..." A Nursing note, dated 2/28/11 at 1400 (2:00 P.M.), indicated "Noted St (stage) 2 open area on coccyx. 1 cm (centimeter) circumference...." This is the area that healed 2/16/11 and had reopened 12 days later. A Nursing note, dated 2/28/11 at 9:00 A.M., indicated "Daughter aware area reopened on coccyx." A Plan of Care, dated 1/25/11 and rewritten 2/28/11,, indicated "Res (resident) at risk for skin breakdown....Hx of healed pressure ulcer...2/28/11 Stage II coccyx area." Approaches: included, but were not limited to, "Low bed with low air mattress...moisture barrier q shift...turn and reposition q 2 hours...naps between meals..." A CNA (Certified Nursing Assistant) assignment sheet, dated 2/28/11, indicated Resident #4 was to be put back to bed after meals. A Nursing note, dated 3/3/11 at 10:30 A.M., indicated "...Resident up only for		**updated accordingly.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to pressure ulcer prevention.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of measures to prevent pressure ulcers.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	meals and is turned and repositioned every 1 - 2 hours...." A Nursing note, dated 3/21/11 at 11:00 A.M., indicated "Area to coccyx healed...." A Plan of Care, dated 3/21/11, indicated "Res (resident) at risk for skin breakdown....Hx of healed pressure ulcer...2/28/11 Stage II coccyx area." Approaches: included, but were not limited to, "Low bed with low air mattress...moisture barrier q shift...turn and reposition q 2 hours...reposition q 2 hrs while up in broda chair- off load pressure." A Physician's summary, dated for the month of April 2011, indicated an order, dated 1/19/10, for a "low bed with overlay air mattress, settings per comfort of Resident..." This is the same mattress overlay the Resident was on when the coccyx opened in February and then reopened in March. During an interview with LPN # 15, on 4/6/11 at 1:30 P.M., she indicated the mattress overlay is inflated and lays on top of the Resident's mattress. The resident is not on a low air loss mattress because hospice takes care of getting the mattresses.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=D	During an observation with CNA #16, on 4/7/11 at 1:15 P.M., the Resident's coccyx was healed and had scar tissue over the bony prominence. 3. Record review for Resident #75 was completed on 4/8/11 at 8:50 A.M. Diagnoses included, but were not limited to, rheumatoid arthritis, depressive disorder, and chronic airway obstruction. Record review indicated resident was admitted on 12/6/10. The admission assessment indicated no open areas noted to coccyx and buttocks. The Braden scale skin assessment done at this time indicated the resident was at high risk for skin breakdown. The Braden scales were completed for the month of December and up to January 19, 2011 will all indicating the resident was at high risk for skin breakdown. A document titled "Resident Weekly Skin Check Sheets" indicated on January 5th, "...Large reddened area on buttocks with open areas..." No measurements were indicated. On January 11th "...Large reddened area on buttox [buttocks] with open area, current tx [treatment] con't [continued]. " No measurements were indicated.		**F314** The corrective action taken for the residents found to have been affected by the deficient practice was: **Resident #65s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #4 was placed on a Low Air Loss mattress at the time of ISDH survey. Resident #4s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** **Resident #75s pressure ulcer has healed. Resident's care plan and CNA assignment sheet have been reviewed and updated, as necessary, to reflect current preventative measures.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is:	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The care plan, dated 12/15/10 with revision dates of 3/15/11 and 3/25/11, indicated Stage II to R and L[left] buttock. Interventions included the following: "... (01) Therapy as ordered (2) Pressure reducing mattress to bed, (03) staff to assist with bed mobility... (05) Skin checks per policy (06) Peri care assist after incontinent episodes (07) (revision date of 3/8/11 noted here) Tx)[treatment] as ordered PRN [as needed]...(09) Notify MD [medical doctor] of abnormal findings (10) urinal @ [at] bedside (11) Assist to use toilet when OOB [out of bed]..." The care plan indicated the resident is at risk for skin breakdown related to decreased physical functioning and use of Prednisone. No interventions were included to address the skin breakdown on 1/5/11. In reviewing of records provided by the DON on 4/8/11 at 9:30 A.M., it was found that there was no documentation of notifying the physician regarding the wound prior to 1/13/11. The physician's order, dated 1/13/11, indicated, "Cleanse R) [right] buttock wounds, apply bacitracin & [and] with dry cover drsg [dressing] BID [twice a day] & PRN [as needed] X [times] 14 D [days] then re-eval [re-evaluate]. The physician's order, dated 1/28/11, indicated cont to cleanse right buttock wound, apply		**Braden scales have been completed for all residents in an effort to identify those residents at risk for development of ulcers. Those residents identified at risk have had care plan reviews conducted to ensure appropriate preventative measures are in place. CNA assignment sheets have been updated accordingly.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurse have been re-educated on provision of necessary care and services, including but not limited to pressure ulcer prevention.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, compliance with implementation of measures to prevent pressure ulcers.** To ensure the deficient practice does not recur, the monitoring system established is: **DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	bacitracin & cover with a dry dressing twice daily and use skin prep prior to applying dressing. In an interview with Resident #75 on 4/8/11 at 10: 20 A.M., he indicated when he came to facility from hospital he did not really remember much from when he first got here. He stated he was in a lot of pain and could not move much the first month he was here. An opportunity was provided to the DON (Director of Nursing) on 4/8/11 at 9:30 A.M. to provide all information regarding all wound treatments, skin sheets, and wound orders from time of admission to current. Another opportunity was given at exit at 4:15 P.M. on 4/8/11, no further information was provided. 3.1-40(a)(2)			
F0371 SS=F	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the	F0371	**F-371**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	facility failed to ensure that the refuse container was covered to avoid food spillage and that the trays of food in the refrigerator were properly covered to prevent possible food contamination. This had the potential to affect 123 of 124 residents receiving meals from the facility kitchen.. Findings include: In a tour with Dietary Worker #13 at 4:45 P.M., of the walk- in refrigerator there was 3 trays of pudding, 2 trays of cookies, and 2 trays of onions that were not covered. In a tour with Dietary Worker #13 at 4:45 P.M., a garbage container did not have a lid on it and there was a box and other food matter in the container. In an interview immediately following the tour, Dietary Worker #13 was questioned about the items found uncovered and she stated that they were typically covered and that she would review this with staff. 3.1-21(i)(3)		The corrective action taken for the residents found to have been affected by the deficient practice was: **The trays of food were covered at the time of ISDH survey.** **The garbage container lid was placed on container at the time of ISDH survey.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **This practice has the potential to affect all residents currently residing in the nursing center. Therefore, this plan of correction applies to all residents.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Dietary staff have been re-educated on facility policy and procedure relative to Kitchen Sanitation, including but not limited to ensuring food is properly covered, and garbage containers are covered.** **A performance improvement tool has been developed that Nutrition Service Manager (NSM), or designee, will utilize to monitor cleanliness of food preparation**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			area and that all food to be stored is covered weekly for one month. To ensure the deficient practice does not recur, the monitoring system established is: **NSM, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	
F0514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
SS=E	Based on record review and interview, the facility failed to ensure the current physician order recap [recapitulation] sheets and/or M.A.R.s	F0514	**F514** The corrective action taken for the residents found to have been affected by the deficient practice was: **The treatment and medication administration records for Resident #57 were corrected at the time of ISDH survey.** **The order for Digoxin level for Resident #59 was discontinued at the time of ISDH survey. Please note that resident did not have this**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	[Medication Administration Records] were correctly transcribed and checked to reflect current physician orders. This deficiency impacted 5 residents in a sample of 24 residents reviewed for accurate records. [Residents #17, #57, #59, #89, and #104] Findings include: 1. In an interview during the initial orientation tour on 4/4/11 at 10:05 A.M., L.P.N. #3 indicated		**laboratory test obtained after the medication had been discontinued. The medication administration record and the rewrite for Resident #59 were corrected at the time of ISDH survey.** **As is stated on the 2567, Resident #104 received the last dose of Rocephin on 3/24/11. The medication administration record and rewrite for Resident #104 were reviewed and corrected at the time of ISDH survey.** **The laboratory orders for Resident #17 have been reviewed with the physician, clarification orders were obtained to reflect physician' s current wishes for laboratory orders.** **The gallbladder catheter order for Resident #89 had been discontinued. The rewrite for Resident #89 has been corrected.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All residents of the nursing center have the potential to be affected. Therefore, this plan of correction applies to all residents currently residing in the center.** **The rewrites of all residents have been reviewed, with necessary corrections made and/or**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident #57 had multiple open areas of his right lower leg and foot, and was receiving Hospice services. The clinical record for Resident #57 was reviewed on 4/4/11 at 1:35 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, urinary retention with supra-pubic catheter, hypertension, contractures, fragile skin, hypothyroidism, and severe peripheral vascular disease.		**clarifications obtained.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses have received re-education relative to maintaining clinical records, including but not limited to ensuring current physician order recaps and MARs/TARs are correctly transcribed and checked to reflect current physician orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor accuracy of physician order recaps and MARs/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARs/TARs for the months beginning May 1, 2011, and June 1, 2011. Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/TARs for an additional 4 months, for the months beginning July 1, 2011 through October 1, 2011.** To ensure the deficient practice does not recur, the monitoring system established is: **Unit Manager, or designee, will review findings monthly and report to PI committee monthly for 6 months to determine need for**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Hospice services were initiated on 12/23/10. A. An order was written on 2/3/11 to "paint Betadine to right heel, right great toe, and left toes daily, and apply non-adhesive dressing." On 3/18/11, the physician added an order to "Apply Betadine to area behind right knee and apply non-adherent dressing. Wrap with Kerlix" The April 2011 physician order recap sheet did not include current treatment		**continued monitoring thereafter.** **Completion Date: April 25, 2011**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	orders for the open areas on the resident's right foot, lower leg--calf, and behind knee. B. On 3/8/11, the physician ordered "Roxinal [a morphine sulfate pain medication] 20 mg./ml. [milligrams per milliliter]=Give 15 mg. sublingual every 2 hours P.R.N. [as needed]. The April 2011 physician order recap and M.A.R. listed the order as "Give 1 mg...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During the daily conference on 4/7/11 at 3:30 P.M., the Director of Nursing was given the opportunity to submit any documentation or explanation related to the discrepancy in the orders. At the final exit on 4/8/11 at 4:00 P.M., the Director of Nursing indicated she had no further information to provide related to the issues that were discussed. 2. The clinical record			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	for Resident #59 was reviewed on 4/5/11 at 10:17 A.M. Diagnoses included, but were not limited to, seizure disorder, insulin-dependent diabetes, C.V.A. [stroke] with right hemiparesis [paralysis] and aphasia, and history of systolic/diastolic heart failure. A. The April 2011 physician order recap sheet, which was dated as checked by a licensed nurse on 3/29/11, listed an order for "9/3/10-			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	-Digoxin level every 6 months/November, May." The resident had been receiving Lanoxin [a heart medication] which was discontinued on 1/6/11. B. On 9/3/10, the physician had given an order for Lasix 40 mg. [milligrams] daily, and the order was listed on the March 2011 physician order recap sheet. The April 2011 physician order recap sheet did not list the Lasix, and there			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	was no order to discontinue the medication. The Lasix medication was listed on the April 2011 M.A.R. In an interview on 4/8/11 at 11:00 A.M., the Director of Nursing indicated physician order information was given to a data entry staff person, who entered the data and printed out the recap sheets, M.A.R.s and T.A.R.s [Treatment Administration Record]. The forms were then given to the nurses on each unit to be checked.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	She offered no other information related to the errors on current recap sheets and M.A.R.s. 3. The clinical record for Resident #104 was reviewed on 4/6/11 at 4:40 P.M. Diagnoses included, but were not limited to, senile dementia--Alzheimer's type, fractured left hip, urinary retention, and chronic obstructive pulmonary disease. The April 2011 physician			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	order recap sheet, which was dated as checked by a licensed nurse on 3/25/11, listed an order of "Rocephin [an antibiotic medication] 1 Gram intramuscular injection every 12 hours." In an interview on 4/7/11 at 1:35 P.M., L.P.N. #16 indicated the resident was prescribed the Rocephin after he returned from the hospital following his fractured hip. She indicated he was no longer receiving the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	medication, and referred to the March M.A.R. for additional documentation. The March M.A.R. indicated the resident received the Rocephin for 7 days, with a stop date of 3/17/11. The Rocephin was continued for an additional 7 days, with a Stop/End date of 3/24/11. The resident received the last 2 doses of the medication on 3/24/11. During the interview on 4/7/11 at 1:35 P.M., L.P.N. #16 also			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	indicated that nursing staff printed the recap sheets and M.A.R.s for the next month, which came to the unit between the 20th and 25th of the current month. The next month's recap and M.A.R. was reviewed and checked by one nurse, and rechecked by another nurse.			
SS=E	4. The clinical record of Resident #17 was reviewed on 4/8/11 at 10:15 A.M. Diagnoses included, but were not limited to, diabetes, depression, high blood pressure and bi-polar disorder. A lab result, dated 3/8/11, was for a CBC (complete blood count). No Physician's order for the CBC was found in the chart. A Physician's Summary, dated for the month of April 2011, indicated Resident # 17 was to have the following: Every three		**F514** The corrective action taken for the residents found to have been affected by the deficient practice was: **The treatment and medication administration records for Resident #57 were corrected at the time of ISDH survey.** **The order for Digoxin level for Resident #59 was discontinued at the time of ISDH survey. Please note that resident did not have this laboratory test obtained after the medication had been discontinued.**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	months a HbgA1C, Valporic acid and CMP and every two months a digoxin level, liver enzymes and a BMP. A Physician's order, dated 6/1/09, received from the Director of Nursing, on 4/8/11 at 2:00 P.M., indicated Resident # 17 was to have a CBC, BMP and HbgA1C every three months. The CBC was not on the Physician's Summary.		**The medication administration record and the rewrite for Resident #59 were corrected at the time of ISDH survey.** **As is stated on the 2567, Resident #104 received the last dose of Rocephin on 3/24/11. The medication administration record and rewrite for Resident #104 were reviewed and corrected at the time of ISDH survey.** **The laboratory orders for Resident #17 have been reviewed with the physician, clarification orders were obtained to reflect physician' s current wishes for laboratory orders.** **The gallbladder catheter order for Resident #89 had been discontinued. The rewrite for Resident #89 has been corrected.** The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All residents of the nursing center have the potential to be affected. Therefore, this plan of correction applies to all residents currently residing in the center.** **The rewrites of all residents have been reviewed, with necessary corrections made and/or clarifications obtained.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses have received re-education relative to maintaining clinical records, including but not limited to ensuring current physician order recaps and MARs/TARs are correctly transcribed and checked to reflect current physician orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor accuracy of physician order recaps and MARs/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARs/TARs for the months beginning May 1, 2011, and June 1, 2011. Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/TARs for an additional 4 months, for the months beginning July 1, 2011 through October 1, 2011.** To ensure the deficient practice does not recur, the monitoring system established is: **Unit Manager, or designee, will review findings monthly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS=E	5. Resident # 89 record was reviewed on 4/7/11 at 9 A.M. Diagnoses included, but were not limited to, small bowel obstruction, Chron's disease, gastric cancer, and gastroenteritis. In an interview with LPN #1 on 4/7/11 at 9:05 A.M., LPN # 1 indicated Resident #89 no longer has a gallbladder catheter and that it was discontinued. The clinical record indicated on the physician rewrites for April 2011 that the resident had a gallbladder catheter. There was no indication on the rewrite that the gallbladder catheter had been discontinued. 3.1-50(a)(2)		**Completion Date: April 25, 2011** **F514** The corrective action taken for the residents found to have been affected by the deficient practice was: **The treatment and medication administration records for Resident #57 were corrected at the time of ISDH survey.** **The order for Digoxin level for Resident #59 was discontinued at the time of ISDH survey. Please note that resident did not have this laboratory test obtained after the medication had been discontinued. The medication administration record and the rewrite for Resident #59 were corrected at the time of ISDH survey.** **As is stated on the 2567, Resident #104 received the last dose of Rocephin on 3/24/11. The medication administration record and rewrite for Resident #104 were reviewed and corrected at the time of ISDH survey.** **The laboratory orders for Resident #17 have been reviewed with the physician, clarification orders were obtained to reflect physician' s current wishes for laboratory orders.** **The gallbladder catheter order for Resident #89 had been discontinued. The rewrite for**	04/25/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Resident #89 has been corrected. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: **All residents of the nursing center have the potential to be affected. Therefore, this plan of correction applies to all residents currently residing in the center.** **The rewrites of all residents have been reviewed, with necessary corrections made and/or clarifications obtained.** The measures put into place and systemic change made to ensure the deficient practice does not recur is: **Licensed nurses have received re-education relative to maintaining clinical records, including but not limited to ensuring current physician order recaps and MARs/TARs are correctly transcribed and checked to reflect current physician orders.** **A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor accuracy of physician order recaps and MARs/TARs. Unit Managers, or designee, will be responsible to check all resident's recaps and MARs/TARs for the months beginning May 1, 2011, and June 1, 2011.**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155378	A. BUILDING 00 B. WING	04/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWOOD HEALTH CARE CENTER	1001 NORTH GRANT STREET LEBANON, IN46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Thereafter, Unit Managers, or designee, will be responsible to randomly check at least 15 resident's recaps and MARs/TARs for an additional 4 months, for the months beginning July 1, 2011 through October 1, 2011. To ensure the deficient practice does not recur, the monitoring system established is: **Unit Manager, or designee, will review findings monthly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.** **Completion Date: April 25, 2011**	